Fidelity House
School Age Child Care Program
Fidelity House Site 2

# Child's Enrollment Form

## Child Information

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____ Identifying Marks:_____

Eye Color:_____ Hair Color:_____ Skin Color:_____

Sex:_____ Height:_____ Weight:_____

## Parent/Guardian Information

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Home Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Cell Phone Number:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Home Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Cell Phone Number:_____

**Additional Information**

Child's Physician:_____
Address:_____ Phone Number:_____
Allergies_____
Special Diets?_____
Individual Health Plan for child with a chronic health condition? _____If yes, please complete attached form.
Copies of any custody agreements, court orders, and restraining orders pertaining to the child? _____If yes, please attach a copy._____
Special limitations or concerns? _____
_____

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**School Age Only**

Current School:_____

School Address:_____ School Phone Number:_____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school.

***Parent/Guardian initials:***_____

_____ _____

**Parent/Guardian Signature** **Date**

If your child is attending Fidelity House during the summer months, we require a copy of immunizations and date of last physical from your child's doctor's office.

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OFF SITE ACTIVITIES PERMISSION FORM

Child's Name_____

I, _____(Parent / guardian) give permission for my child to participate in all of the regularly scheduled on-going activities located at the following off-site facilities:

_____

| | |
|---|---|
| Fidelity House 25 Medford St. | Minuteman Bike Trail |
| FiHo 2 51R Medford St. | Minuteman Regional High School |
| Arlington Reservoir | Magnolia Field |
| Bishop School Playground | Parallel Park |
| Buzzell Field | Arlington Recreation / Skating Center |
| Fox Library | Robbins Farm Playground |
| Hardy School Playground | Robbins Library |
| Lexington Park | Spy Pond Playground |
| Menotomy Rocks Park | Thompson School Playground |

_____

The program will provide, in writing, a list of scheduled activities.

_____ _____

**Parent / Guardian Signature** **Date**

**Media / Photo Release**

I hereby affirm that I am the parent /guardian of_____(child's name) and I give my consent for photographs of this child, by and for Fidelity House, to be used and or reproduced for the purpose of display, website, future brochures and newspaper releases.

_____ _____

**Parent / Guardian Signature** **Date**

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## Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

**MY CHILD WILL ARRIVE AT THE PROGRAM**:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

**MY CHILD WILL DEPART FROM THE PROGRAM**:

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

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PARENT /GUARDIAN SIGNATURE_____ DATE_____

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION**

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# FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____
*For any chronic health conditions please complete the attached **Individual Health Care Plan**

**Emergency Contacts (*In order to be contacted*)** We always contact Parents first, then the Emergency numbers if necessary.
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____
Policy #_____
Parent/Guardian Name: _____ Phone_____
Cell_____
Parent/Guardian Name: _____ Phone_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

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**MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)**

**Please complete this form if your child requires any medication while at Fidelity House. Please note, we do not administer any medication unless you provide it for your child along with completed paperwork.**

Name of child: _____

Name of medication: _____

Please ✓ one of the following:
-Prescription: _____
-Oral/Non-Prescription: _____
-Unanticipated Non-Prescription for mild symptoms_____
-Topical Non-Prescription (applied to open wound/ broken skin)_____

Please ✓ one of the following:
-My child has previously taken this medication_____
-My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication:
_____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

**Child's Health Care Practitioner Signature** _____Date_____

I, _____, (parent or guardian) give permission
(print name)
to authorize Fidelity House staff to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____

# Individual Health Care Plan Form

**Please complete this form if your child has any chronic health conditions and/or allergies which may require treatment.**
**Plan must be renewed annually or when child's condition changes.**

*Check all that apply….*

**Plan was created by:**
__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)

**Plan is maintained by:**
__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

| |
|---|
| Name of child: Date: |
| Any change to the child's Health Care Plan?<br>**YES** (indicate changes below) **NO** (updated physician/parental signatures required) |
| Name of chronic health care condition: |
| Description of chronic health care condition: |
| Symptoms: |
| Medical treatment necessary while at the program: |
| Potential side effects of treatment: |
| Potential consequences if treatment is not administered: |
| Name of educators that received training addressing the medical condition: |
| Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant): |

Name of Licensed Health Care Practitioner (please print):_____
Licensed Health Care Practitioner authorization:_____ Date:_____
Parental/Guardian consent: _____ Date:_____

***For Older Children ONLY (9+ years of age)***

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO
Parent signature: _____ Date: _____
Administrator's signature: _____ Date: _____